Social work disaster emergency response within a hospital setting

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Abstract

This article outlines the social work contribution to a series of post-disaster emergency response interventions occurring in the Canterbury region between 2007 and 2012. While the earthquakes of September 4th 2010 and February 22nd 2011 provide the major focus for discussing the tasks and processes involved in emergency response interventions, an earlier critical incident involving a large number of youth prompted the development of the emergency response protocols. These protocols are discussed in light of the social work response to the Canterbury earthquakes. The challenges encountered through working in a rapidly changing physical and professional context are outlined including a discussion about the application of diverse forms of debriefing. New learning for social work practice derived out of engagement with emergency response work is summarised.

Developing an emergency response

New Zealand has had its share of catastrophic events, including natural disasters, major mining accidents and fatalities arising from extreme sporting activities ('Worst Mining Disaster', 2012; '11 Dead in Hot Air Balloon Tragedy', 2012). As such, social work services within hospital settings need to be prepared to respond effectively to a diverse range of crisis situations. The Social Work Service at Christchurch Hospital is recognised as an important part of the trauma response work in the Emergency Department (ED) of the hospital. Social work has a seven-day-a-week presence in the ED and is available on call after-hours. After-hours on-call service provision has been made available within the hospital for the past 10 years. Social workers, experienced in working in the ED have developed a training package for colleagues before they are required to work on call. This training includes a familiarisation with the environment and procedures used when working in the ED and an overview of the theories that underpin trauma response. Practitioners on call for the first time are offered the opportunity to request assistance from a designated ED team social worker to accompany them to their first after-hours call back to the hospital. In addition to the after-hours on-call service, where social workers usually work alone, an Emergency Response Team was formed in 2007. The concept for this team evolved out of a specific incident from an after-hours call back to a multiple trauma involving a large number of youths struck by a car outside a party. There were six critically injured youths and many others sustained lesser injuries. A crowd of approximately 250 youths began to arrive at the hospital within minutes of the accident occurring. On this particular night the on-call social worker was on duty for the first time and requested assistance. During the debriefing

following this event, it was recognised that cell phone contact had contributed to the size of the crowd and the speed by which it had gathered. It became evident that the hospital social work service had no plan in place to manage crowd control post traumatic events. For Social Work Services this was the first time where social networking through use of digital technology significantly impacted on service delivery.

At this time the need was identified for a core group of practitioners to undertake in-depth training regarding trauma response and the support of large numbers of concerned people. A comprehensive policy to guide this particular work was developed using the format of the Coordinated Incident Management System (CIMS) (NZ Fire Service Commission, 1998). This policy provides a clear organisational framework stating specified roles and tasks to be undertaken during an emergency response. The policy is recognised within the hospital's Emergency Response plan and includes provision for the Clinical Manager for social work to activate the Emergency Response Team before the hospital's Emergency Controller calls an emergency response for the hospital as a whole. Experience has shown, with the exception of the ED receiving patients, Social Work Services need to be in place to manage the influx of relatives and others well before other parts of the hospital response come into play.

Emergency response roles and tasks: Looking back over 18 months

On September 4th 2010 an earthquake measuring 7.1 on the Richter scale struck the city of Christchurch at 4.30am. The after-hours on-call social worker was asked to come into the hospital in anticipation of people presenting to the ED with injuries. In this event, minimal social work input was required for the small number of people who were treated for injuries. On that particular day there were patient deaths from natural causes that would normally be managed by the Mortality Office. Staff from the Mortality Office were unable to travel to work at the hospital site due to road damage. Social work personnel were asked to oversee the support of relatives and attend to the legal procedural requirements set out in the Coroner's Act 2006. The hospital Duty Manager worked with social work staff carrying out these duties. Practitioners were not at the time completely familiar with all aspects of the Coroner's Act. As telephone communication was restored advice and guidance on these matters was able to be sought from the Mortality Office staff member and directly from the Coroner.

Immediately following this first large earthquake, social work staff devised an information sheet of community support agencies that could provide help to individuals, relatives and families. This information was updated twice daily and distributed widely across the Christchurch District Health Board (CDHB). A social worker was based in the ED to respond to queries regarding supports available to patients upon discharge from the hospital. The Clinical Manager's cell phone was programmed to send global text updates to all staff regarding the changing status of hospital services. This strategy has been affirmed by recent research on disaster management signalling the importance technology plays in the sharing of critical information in a timely way with affected staff (Kim, Sharman, Cook-Cottone, Rao, & Shambhu, 2012).

During the first series of earthquakes there were times when travelling into work was potentially hazardous for some staff. It was agreed that practitioners needed to exercise self determination regarding their own availability to work. Each person's decision was respected on an individual basis. The rationale for this allowance was directly related to working with

the CIMS model. Not all staff should be working at any one time. Those who were initially able to work needed to be relieved by those who had not been involved during the initial response (NZ Fire Commission, 1998, p. 49). A similar approach was taken as part of the social work response to the Port Arthur massacre during 1996 (Whelan, 1998). For some workers, their reaction to those events was so intense and personal they were not able to contribute effectively to service provision immediately after the shootings, with professional value being placed on cumulative team responses over time rather than individual contributions during the stage of intense crisis (Whelan, 1998). This notion of valuing different types of involvement in the wake of responding to the ongoing earthquake events was integral to managing the diverse reactions to the earthquakes amongst social work staff.

During November 2010 the Emergency Response Team was put on 'standby' as a result of the mining disaster at Pike River on the West Coast of New Zealand, with Christchurch Hospital being the closest specialist facility to that region. At this time it was envisaged that practitioners would have a role in the support of relatives. The next day a second explosion in the mine indicated that there was little likelihood of survivors and the standby was cancelled. The Pike River mining disaster was the first of several additional emergency responses that were to intersperse those related to subsequent earthquakes in the greater Christchurch region.

The earthquake that occurred at 12.51pm on the 22nd February proved to be the most critical challenge to all emergency services including the hospital social work department. Although lower in magnitude than the September quake, being just 5km deep, close to the city centre and during the middle of the day meant there was far greater devastation to property, resulting in the loss of life for over 180 people and serious injuries to many more. Occurring as it did during the lunch hour, some social workers were offsite at the time. A few were actually in the central business district when the quake hit. A number were working on the wards while others were taking their break at the social work department which is located five minutes walk from the main hospital.

The department is situated in a building that had recently been refurbished to withstand the impact of a severe earthquake. For those located in that building the extent of the damage outside was impossible to assess. The first information to indicate the seriousness of this earthquake was news that a bus had been crushed. At that point the emergency plan was activated and a team leader assigned to take a group of practitioners across to the ED. Immediate efforts were made to locate all social work staff and ensure those who needed to leave for home had the means to do so. During this time the department was inundated with calls, in person and by telephone, from anxious patients, family and friends of staff. The final task before the social work team all left the department to base themselves in the ED was to write up a list of all staff, noting who had not been at work on the day and who had left for home or were working in the ED. This list was dated and timed and stuck to the external door. Walking across to the hospital, the sight and sound of helicopters landing in the street, with people being treated outside in the cratered and cracked car park gave a graphic first impression of the impact of this earthquake.

Setting up a relatives' centre was an immediate response to the crisis. The centre was staffed by social work and police personnel, and became a collection point for gathering information to assist with linking patients to family members and the identification of de-

ceased persons. Creative thinking on the part of practitioners, in both the relatives' centre and the ED resulted in making successful connections between patients and family. One instance was finding a name inside the shoe of a seriously injured person. Some hours later another social worker found that person's name on an appointment card in the bag of another critically ill patient. (Corin 2011). This connection led to nursing staff in the Intensive Care Unit contacting a family member to advise that two relatives were patients in the hospital.

It was quickly realised that the social work response was going to need to be rostered to provide 24-hour cover. A small group of social workers were stood down to rest and were asked to return later in the evening to work through the night. Some managed to get home, while others rested in the social work department. The social work service was divided into two 12-hour shifts. Those who worked through the night over the first three days undertook some different tasks, partly due to the changing momentum of the hospital response and the contrasting international time zones. One of the first tasks to emerge was contacting next of kin of those patients being evacuated to other centres throughout New Zealand. Once contact had been made with a patient's relative this was noted in the clinical file along with messages from family.

Social work staff are used to fielding queries about missing persons from relatives overseas. However, recognising bogus queries from the media quickly became a new skill. Calls also came from overseas insurance companies seeking information about patients from countries other than New Zealand. In the early hours of the first morning social work staffing was requested to assist nurses on the wards to calm agitated patients who had become separated from those they were with at the time of the earthquake. Social work personnel also worked alongside the hospital's emergency controller to locate hospital admission documents written by hand in the early hours of the response, when computers were inoperable. Once again, updated information about the availability of community services was compiled by social workers for distribution across the hospital and the CDHB.

Challenging times

Practitioners experienced a number of challenges during these earthquake events that were of a practical and psycho-social nature. Computers and telephone communication were frequently unavailable or unreliable. Lighting was intermittent and practitioners had to navigate their way along very dark corridors during night-time hours. Workers resorted to using cell phone flashlights to navigate around some parts of the hospital. During the first hours after this earthquake staff were legitimately concerned about not being able to contact their own family. There were realistic worries that they might know some of the injured.

Following the February earthquake the central city was cordoned off and a national state of emergency was declared. City businesses were closed down immediately with many buildings damaged beyond repair. Many of the city's roads were impassable due to damage and flooding, liquefaction and cracking. Power, sewage and water supplies were severely compromised. Many households in some suburbs of the city were still using portable toilets months after the February quake. Housing damage resulted in thousands of people needing to relocate to safer locations outside of the city (Sachdeva & Levy 2011). The city quickly became a site of large-scale destruction due to both the quakes and demolition of dangerous buildings.

Making adjustments: Working and living amongst change

The winter following the February earthquake was very cold, resulting in the whole of the South Island experiencing record-breaking snowstorms during June and July. From a social work service response there was no direct call for intervention. However, many practitioners had difficulty getting into work, leaving staffing numbers depleted. During the July storm the hospital management took a different view toward individual circumstances. A clear message was sent out that all hospital staff should see themselves as providing an 'essential' service. A special payment for 'snow leave' made for the June storm was not repeated in July. This approach affected team morale.

During May 2012 a school bus crash requiring social work intervention provided an interesting foil for practitioners to the emergency response within the context of the earthquakes. A sense of 'business as usual' ensued, with just minor injuries being sustained by passengers. For this event there was no conflict between workplace and home commitments and loyalties. The bus crash highlighted how the nature of this incident, while serious, was much more within the realms of a contained trauma response that the practitioners are used to, as opposed to the multi-layered impact of responding to fallout from a natural disaster that had capacity for widespread injury and devastation.

All staff, both social workers and administrative support, have lived in a state of alert for a period of 18 months. The personal toll of each earthquake event and emergency response varied according to individual circumstances. In September 2010 there were no deaths, and only a small number of hospital presentations directly attributed to the quake. During February 2011 the death toll and level of multiple injuries sustained by the general population had a greater impact. A number of those admitted to hospital in February were of similar age to some social workers. During this event few staff escaped damage to homes and belongings. Liquefaction and lack of utilities for days, and sometimes weeks left staff feeling doubly depleted. Another significant aftershock during June 2011 resulted in few injuries and no fatalities, but on the home front there was more liquefaction to deal with and disruption once again to essential utilities.

In the workplace, the hospital moved quickly to make organisational changes to the way many services were delivered. Two hundred damaged buildings and up to 14,000 damaged rooms meant that many of those changes were made out of necessity. Additional changes to service delivery were instigated out of new opportunities created through building alterations. The rapid pace of change caused by both meeting needs and accessing opportunities created additional worker stress. One adjustment that had positive spinoffs for social work was accommodating Nga Ratonga Hauorua Maori Health for 11 months within the social work department. While finding additional desk space for another department put pressure on all parties, the cramped conditions were outweighed by the benefits of strengthening the working relationship between the two services.

A heightened sensitivity to what is happening elsewhere in the world and around the country was evident. Tragic events brought mixed feelings of relief, that it was not yet again our turn, and deep compassion for those undergoing their own experience of disaster. The Pike River mine disaster from November 19th 2010, the earthquake and tsunami that occurred in Japan on March 11th 2011, and multiple flood and cyclone events elsewhere within New Zealand and Australia were just some incidents that reignited memories of personal loss.

One of the most sustaining inputs for social work staff has been regular affirmation in many forms. Messages and care packages from colleagues across the country and Australia at the time of the earthquakes, Christmas and on the first anniversary of the February 22nd quake have been significant morale boosters. In response the department has endeavoured to be more deliberate and proactive in providing support and acknowledgement when social work colleagues in other parts of the country and around the world are involved in disaster response. Recognition of 'the outstanding professionalism and dedication on February 22nd and in subsequent weeks' (Corin, 2011, p.62) was greatly appreciated by the team.

As the workplace has regained a sense of normality a group of social workers have organised regular social events including hosting a pink breakfast as a fundraising effort for breast cancer research, and celebrating Melbourne and NZ Trotting Cup races with fancy dress and lunch. These fun times have gathered staff together and encouraged a light and cheerful mood. Recent research in the human service sector cites the significance of peer support and the encouragement of team social activity as important factors for enhancing staff morale and workplace satisfaction (van Heugten, 2011). In addition the 2012 round of worker performance appraisals was used as another opportunity to acknowledge the professional contribution practitioners made to each emergency response.

Using different forms of debriefing

While there is popular support for providing debriefing for workers who have taken part in a disaster event, evidence regarding the effectiveness of debriefing as a process is far from conclusive (Deahl & Bisson, 1995). In particular, doubts have been raised about single session debriefing within 24 to 72 hours immediately after an event, where there is potential for increasing levels of distress (Muskett cited in Paine, 2005). Instead, it is suggested that the debriefing process occur within the context of ongoing structured social support (Atle & Regel, 2012).

The various types of incidents discussed above warranted different forms of 'debriefing'. After the September quake where there had been no loss of life, using music proved to be an appropriate form of release and a way to bring the team together (Jenson, 2005). A light-hearted approach was used where staff brought a 'quake-related' song title to a staff meeting and shared their choice with colleagues. This approach reflected strategies used throughout history where there has been heavy reliance on music and the arts to cope with trauma and disaster (Otera, 2012; McLeese, 2008). Subsequent events required different forms of debriefing.

Two weeks after the February 22nd earthquake, social workers were invited to meet with the senior doctor and nurse on duty that day to hear the medical perspective to the emergency response. This was an opportunity to experience reciprocal appreciation of the contribution all professions made to the response. The social workers remained afterwards and were joined by all staff in the department and Nga Ratonga Hauori Maori Health Services for a facilitated meeting simply to share stories. Eighteen months on the facilitator for this event has a vivid recollection of the stories shared at that meeting (V. Wright, personal communication, October 15th 2012).

When the earthquake and tsunami occurred in Japan on March 11th, with graphic television coverage, a meeting occurred with groups of social workers before they went onto the wards that day. The purpose of the meeting was to simply acknowledge that the news reports could rekindle memories of the Christchurch earthquakes for both staff and patients. Although not debriefing in its purest sense, the meeting was held as a proactive measure to address potential sensitivities. Over time professional supervision has been used as an important space for individual social workers to debrief in keeping with providing ongoing structured support (Atle & Regel 2012).

New learning

The events of the last two years have afforded the social work team at Christchurch Hospital many opportunities for new learning. While practice scenarios used as part of the initial emergency response training had included setting up a relatives' centre, the application of this process in a real event had not been tested. Working with the Police to identify deceased persons was a new task, and arguably one of the most challenging for social workers during the February earthquake response. Not only was this process additional to the normal range of duties, the chaotic physical conditions created by the earthquakes made the task challenging. In particular, linking patients who had become separated from relatives called for a creative and concerted application of 'professional curiosity' (Milner, 2008).

The rapid expansion of service to provide 24/7 social work coverage during the first days following the February earthquake, and then an ongoing seven-day service tested the skills and endurance of both practitioners and management. On reflection, the plan to provide a 24-hour service was ambitious in that the team was only divided into two 12-hour shifts. The difficulties in getting to and from work for staff were not foreseen. What had previously been a 10 to 15 minute car trip became one that for some could take hours. At home, many staff were also dealing with damaged homes and liquefaction. The 12-hour shifts did not give staff sufficient time to rest and replenish before returning to work.

During these periods service delivery from community-based organisations was compromised, with some services being closed and others offering only limited outreach. Practitioners had to draw on creative problem solving skills to ensure patients would be safe to discharge home. Relief in the form of social workers coming from other district health boards from around the country at this time was invaluable, enabling the department to meet the needs of patients and the organisation.

In November 2011 the Clinical Manager of Social Work at Christchurch Hospital attended a meeting with the Council of Social Work Educators Aotearoa New Zealand (CSWEANZ). The purpose of this meeting was to discuss the curriculum content for a social work education paper or course specifically related to disaster response. The panellists included representation from non government organisations, Civil Defence and health who had all been part of the response to the Christchurch earthquakes. There was clear consensus during this meeting that there did not need to be a course specific to disaster response. It was agreed that much of the core social work curriculum already delivered in New Zealand social work qualifications equipped practitioners to work in this context. Education provided on areas related to crisis intervention, problem solving, practice skills, networking, community development, mobilising and utilising local resources were considered to be particularly relevant.

Fook, Ryan and Hawkins (2000) suggest that professional expertise involves the ability to create knowledge from experience in context, and the capacity to transfer that knowledge into different situations. For a number of years the social work department has provided the opportunity for less-experienced practitioners to rotate their positions across a range of service areas. This system exposed team members to a variety of practice approaches and learning contexts. During the various emergency responses discussed in this article practitioners' experience of adapting to new service requirements equipped them to adjust quickly to tasks that fell outside their usual scope of work. In hindsight, the system of rotating practitioners through different clinical settings has proven its worth in terms of equipping multiple team members to be both knowledgeable about diverse specialities and quickly adaptable. Both of these qualities were invaluable in providing effective and timely social work emergency responses.

Conclusion

Disaster preparedness and disaster planning are not always the same thing (Kirsch et al., 2010). Although the social work department had policy and guidelines and a clear organisational framework with specified roles, social workers were required to assume roles outside what was planned in an environment where communication, utilities and transport facilities were often severely compromised. The key tasks outside of the normal social work role were crowd control, assisting with the identification of victims, working within the requirements of the Coroner's Act 2006, and fielding media queries. All of these would, in part or entirely, usually be performed by other staff within the hospital setting. It was discovered that to undertake these tasks knowledge and skills used in daily practice were completely transferable to this disaster response context.

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